TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AMARILLO SPINE & REHAB CENTER

Respondent Name
TEXAS DEPARTMENT OF TRANSPORTATION

MFDR Tracking Number
M4-14-3408-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
JULY 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Requestor did not submit a position summary in the dispute packet.

Amount in Dispute: $1,795.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Below is a summary of each date of service listed on the dispute and the attached document provides additional detailed information for each date of service below. Also attached are copies of each CMS 1500 submitted to Carrier with Carrier's responding EOR."

Response Submitted by: Texas Department of Transportation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2014	CPT Code 99203-25	$95.00	$0.00
January 15, 2014 January 16, 2014 January 22, 2014 January 31, 2014 February 7, 2014 February 11, 2014 February 19, 2014 February 26, 2014	CPT Code 97140-GP-59	$40.00/ea	$0.00
January 15, 2014 January 16, 2014 January 21, 2014 January 22, 2014	CPT Code 97035-GP	$35.00/ea	$15.74
January 15, 2014	CPT Code 72050	$95.00	$0.00

January 15, 2014	CPT Code 72070	$50.00	$0.00
January 15, 2014	97750-59	$75.00	$0.00
January 16, 2014	CPT Code 99212-25	$60.00	$0.00
January 16, 2014 January 22, 2014 January 31, 2014 February 7, 2014 February 19, 2014 February 21, 2014	CPT Code 97110-GP-59	$100.00/ea	$0.00
January 16, 2014 February 11, 2014 February 19, 2014 February 21, 2014	CPT Code 98940	$50.00/ea	$0.00
January 16, 2014 February 20, 2014	CPT Code 99080	$15.00/ea	$0.00
January 21, 2014	CPT Code 97110-GP	$50.00	$48.01
February 11, 2014 February 19, 2014	CPT Code G0283-GP	$20.00/ea	$15.60
TOTAL		$1,795.00	$79.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the rule for medical bill submission by a Health Care Provider.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - B20-Payment adjusted because procedure/service was partially or fully furnished by another provider.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - 18-Exact duplicate claim/service.
   - 29-The time limit for filing has expired.
   - 16-Claim service lacks information which is needed for adjudication. Remark codes whenever appropriate.
   - Per rule 133.20(d)(2); the health care provider that provided the health care shall submit its own bill, unless the healthcare was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill.
   - Appears to be a reconsideration but not submitted properly per rule 133.250. Missing 73 modifier.
   - 59-Processed based on multiple or concurrent procedure rules.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

- P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- Please submit exercise flow sheet to support time/units billed for further review.
- Please submit with required modifier (GP, GO, GN) for further review.
- The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPCS code(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule.

Issues

1. Is the requestor entitled to reimbursement for services rendered on January 15, 2014?
2. Is the requestor entitled to reimbursement for services rendered on January 16, 2014?
3. Does a timely filing issue exist for services rendered on January 21, 2014? Is the requestor entitled to reimbursement?
4. Does a timely filing issue exist for services rendered on February 11, 2014?
5. Does the documentation support billing code G0283 rendered on February 19, 2014?
6. Does the documentation support billing code 99080 rendered on February 20, 2014?
7. Is the requestor entitled to additional reimbursement for services rendered on January 22, 31, February 7, 19, and 21, 2014?

Findings

1. On January 15, 2014, the requestor billed CPT codes 99203-25, 97140-GP-59, 97035-GP, 72050, 72070 and 97750-59 that was denied payment based upon reason code "B20-Payment adjusted because procedure/service was partially or fully furnished by another provider."

   28 Texas Administrative Code §133.20(d)(2) states, "The health care provider that provided the health care shall submit its own bill, unless: the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill."

   28 Texas Administrative Code §133.20(e)(2) states, "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The Division reviewed the submitted bill, medical records and supporting documentation and finds the following:

   - Dr. J. Todd Whitehead, DC is listed in box 31 of the medical bill.
   - The Initial Evaluation is signed by Jon Blackwell, DC.

   The documentation does not explain the relationship between Dr. Whitehead and Dr. Blackwell to support a billing arrangement to circumvent the requirements of 28 Texas Administrative Code §133.20(d)(2) and (e)(2); therefore, reimbursement is not recommended because the rule specifies that the medical bill must be submitted by the licensed health care provider who provided the service. As a result, reimbursement is not recommended.

2. On January 16, 2014, the requestor billed CPT codes 99212-25, 97110-GP, 97140-GP-59, 98940, 97035-59 and 99080 based upon reason code "B20-Payment adjusted because procedure/service was partially or fully furnished by another provider."

   The Division reviewed the submitted bill, medical records and supporting documentation and finds the following:

   - Dr. K. Jeremy Raef is listed in box 31 of the medical bill.
   - The Report of Findings is signed by Jon Blackwell, DC.

The documentation does not explain the relationship between Dr. Whitehead and Dr. Blackwell to support a billing arrangement to circumvent the requirements of 28 Texas Administrative Code §133.20(d)(2) and (e)(2); therefore, reimbursement is not recommended because the rule specifies that the medical bill must be submitted by the licensed health care provider who provided the service. As a result, reimbursement is not recommended.

3. According to the explanation of benefits, the respondent denied reimbursement for services rendered on January 21, 2014, CPT codes 97110-GP and 97035-GP, based upon reason code "29-The time limit for filing has expired. The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC code(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule."

   28 Texas Administrative Code §133.20(b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   A comparison from the original claim and corrected claim finds that the only change on the bill was the addition of GP modifier to code 97110 and 97035; therefore, the respondent's denial based upon reason code "29" is not supported; therefore, reimbursement per 28 Texas Administrative Code §134.203(c) is recommended.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   On the disputed date of service, the requestor billed CPT codes 97110-GP, 97140-59-GP, 98941, and 97035-GP. CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011, which states in part, "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed services.

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 79106, which is located in Amarillo, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

   The 2014 DWC conversion factor for this service is 52.83.

   The 2014 Medicare Conversion Factor is 35.8228.

Using the above formula and multiple procedure rule discounting policy, the Division finds the following:

Code	Medicare Participating Amount	MAR	Insurance Carrier Paid	Total Due
97110-GP	$30.85	$48.01	$0.00	$48.01
97035-GP	$12.41	$15.74	$0.00	$15.74

4. According to the explanation of benefits, the respondent denied reimbursement for services rendered on February 11, 2014, CPT codes 97140-59-GP and G0283-GP, based upon reason code"29-The time limit for filing has expired. The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC code(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule."

   A comparison from the original claim and corrected claim finds the following:

   - code 97140-GP-59 was added; and
   - modifier "GP" was appended to code G0283.

   The insurance carrier date stamped a receipt date of the corrected claim on May 22, 2014, this date is 100 days from the date of service.

   The Division finds that code 97140-GP-59 was not submitted within the 95 day deadline; therefore, the respondent's denial based upon reason code "29" is supported. As a result, reimbursement is not recommended.

   Regarding code G0283, the respondent's denial based upon reason code "29" is not supported because the code was on the original bill; therefore, reimbursement per 28 Texas Administrative Code §134.203(c) is recommended.

   Using the above formula, the Division finds that the MAR for code G0283-GP is $15.60; this amount is recommended for reimbursement.

5. According to the explanation of benefits, the respondent denied reimbursement for code G0283-GP rendered on February 19, 2014 based upon reason code "16-Claim service lacks information which is needed for adjudication. Remark codes whenever appropriate."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   G0283 is defined as "Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care."

   The February 19, 2014 Follow-Up Visits report does not document code G0283; therefore, the respondent's denial is supported. As a result, reimbursement is not recommended.

6. The respondent denied reimbursement for code 99080 rendered on February 20, 2014 based upon reason code "16-Claim service lacks information which is needed for adjudication. Remark codes whenever appropriate."

   CPT code 99080 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

The submitted medical records does not contain a report to support billing CPT code 99080; therefore, the respondent's denial based upon reason code "16" is supported. As a result, reimbursement is not recommended.

7. The insurance carrier submitted documentation to support that payment was issued for services rendered on January 22, 31, February 7, 19, and 21, 2014.

   The Division attempted to contact the requestor's representative, Whitney, via email on August 20, 2015, and telephone on November 30, 2015, to verify that payment was received and services remained in dispute. At the time of the review, the requestor's representative did not respond to the Division's request.

   Using the above formula, the Division finds that the respondent paid for the disputed services and additional reimbursement is not due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $79.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $79.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/09/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.